

TESTIMONY TO
HOUSE INSURANCE COMMITTEE
S.B. 248 (S-3)
April 22, 2015

I am Michael Dabbs, President of the Brain Injury Association of Michigan (BIAMI) and Secretary of CPAN and on behalf of the members of both organizations I wish to express our opposition to S.B. 248 (S-3).

Let me begin by providing you with some responses to questions raised during yesterday's hearing.

- A. Traumatic Brain Injury (TBI) is defined as a blow or jolt to the head, or a penetrating head injury that disrupts the function of the brain and is the largest subset of Acquired Brain Injury (ABI). To give you a better idea of the significance, I've included a diagram showing you the relationship, as well as fact sheet that provides you with the incidence of TBI's in MI.
- B. In regards to why legislators haven't heard more from non-auto related survivors of a brain injury and their families, let me address this with the following points:
 - 1) As mentioned, typically brain injuries resulting from a car crash are the most severe and thus, have the greatest needs for service. However, for non-auto brain injuries, the greatest impediment to services is health care insurance having limitations on services required; as well as not providing cognitive rehabilitation on many plans. This latter point is due to the difficulty in getting Medicare to recognize this service though more health plans are doing so. Without adequate insurance coverage, rehabilitation is limited.
 - 2) Brain Injury Rehabilitation is a relatively new science – approximately 35 years old. The type of medical science and technology needed to handle a brain injury case has only in recent years become more common place in hospitals. Due to the Iraq War, the Dept. of Defense has made significant funding available. Overall, the federal government has devoted only \$17 – 31M dollars to fund multiple brain injury state projects, research and for the CDC.
 - 3) Distributed to the committee this afternoon is an article that appeared in *Bloomberg's Business Week*, December 28, 2012 that depicts the horrendous state of affairs for persons who sustain a brain injury in the U.S. – in fact, calling it inhumane. Because of Michigan's No-Fault Insurance System, we have taken care of a significant portion of this issue in Michigan. Contrast this lack of care and rehabilitation with the letter from the Dingwall Family that is provided.
 - 4) For the past 10 years, BIAMI and other brain injury advocates have worked with the MI. Dept. of Community Health to create and submit a Brain Injury Medicaid Waiver in order to broaden the numbers of non-auto survivors able to receive services.

- 5) Here are the numbers of the Commission on the Accreditation of Rehabilitation Facilities (CARF) accredited programs – this accreditation is designed to assure quality best practices are delivered. Note – there are many other non-accredited programs and services that are vital to those recovering from a brain injury.

<u>STATE</u>	<u>TOTAL CARF SITES</u>	<u>ACUTE REHAB</u>	<u>POST-ACUTE PROVIDERS</u>
MI	138	5	12
NJ	83	3	4
PA	102	8	15
TX	44	4	12
CA	28	14	7

Let me be clear that we are not opposed to reform; but rather, would urge you to take the time necessary to learn of the consequences this legislation would likely precipitate. We acknowledge and appreciate that S.B. 248's sponsor did not put life-time caps into this bill, as was done last session. However, the current legislation addresses a number of new issues not previously addressed and hence, it causes us to be concerned about the consequences.

Believe me, we would have much rather sat down and discussed these issues prior to this bill being drafted; but regrettably, we were not availed of this opportunity and hence, our only recourse was to respond by attending this hearing.

Specifically, I want to address the Attendant Care portion of this bill. Included with this testimony is the BIAMI Attendant Care Position Paper, which is working document reflecting what we believe are some needed reforms. You will note that our suggested changes are aimed at ensuring what is best for the survivor of a brain injury, their families, as well as ensuring that insurance companies can better document the care provided and that their payment is for the only the services as prescribed. Let me add that we have shared these concepts with the insurance industry during our discussions of the past few months and they seem to feel it was a good framework from which to work.

In addition, please consider the following:

1. Unlike any other injury, a person with a serious brain injury in nearly all instances is unable to direct their care. The persons' brain injury affects their cognitive abilities, physical abilities, behavioral responses, and emotions. The significance of this point is that the survivor of a brain injury may not respond, or respond inappropriately to non-family care givers.
2. Multiple caregivers from an agency can exacerbate this issue. Having changes in personnel, week-to-week; month-to-month is disruptive to the individual and to the family. The ability of agency caregivers to get to the survivors' home also is problematic in winter conditions, especially in more rural settings.

3. The irony of the proposed changes to Attendant Care is that they will end up increasing the cost to insurance companies by forcing families into sub-acute care facilities, or possibly nursing homes, or having to utilize a Home Care Agency – all of which are more costly options. And we all know that more cost to insurance companies' means higher premiums we pay. I truly do not believe this consequence is what you want to achieve with your efforts to reform the auto no-fault insurance system.

Let me ask you to consider these serious flaws in the current bill:

- A. Sec. 3107C (1)(A): As was noted yesterday by Sen. Hune, this section is not written to conform to his intended ideas. I would urge this section being amended to conform to the ideas stated in our Position Paper. I trust this section will be revised as was stated in yesterday's hearing.
- B. Sec. 3107C (2): On initial reading of this section the limitation of 24 hours per day would seem reasonable – and for most cases, it may be. However, there are individuals with severe brain injuries who have limited to no ability to move their body; and certainly many spinal cord injured survivors who will need to be transferred from their bed, to a chair, to the toilet or shower, etc., that require at least two persons to move them. This is typical protocol in hospitals and there is nothing different in the home, should this be necessary. Thus, this needs to be changed.
- C. Sec. 3107C (5): This section and its intention are confusing and has multiple implications that are problematic. This hastily worded section needs much greater attention to language and clarifying its intention.
- D. The New MCCC – while I am not expert on this area, I can't help but wonder about our families who are in the current MCCA system as to what will happen to them if they are involved in another serious auto crash with their loved-one with a brain injury. Will their case be transferred to the new MCCC; or will they have to deal with both the MCCA and the MCCC? What happens if the new injuries' compounds the previous injuries, who will pay this? This is what I mean by unintended consequences.

We have heard some legislators say that costly insurance premiums are the biggest complaint they hear. So let me ask you, where in this bill does it direct the insurance industry to reduce their premiums? Maybe you would be wise to consider the approach the Detroit City Council recently took in demanding the Red Wings put in writing what they would do in terms of rehabilitating a hotel on the site of their new arena. Let me urge you to put in this legislation language that directs the insurance companies to reduce their premiums.

Lastly, I would remind the committee that CPAN and BIAMI have a joint lawsuit against the MCCA for their failure to be fully transparent that is currently in the MI. Supreme Court. If you believe as this bill's sponsor did that there is enough wrong with the MCCA to ultimately eliminate it and establish a new MCCC entity; doesn't it make sense you would want to know the findings of the court before you launch into a completely new organization?

Again, we are opposed to S.B. 248 (S-3) as written. A more deliberate approach with people from both sides of this issue advising you is required, if you truly want to reform the auto no-fault insurance system. Otherwise, you will create unintended consequences that will take years of litigation to correct and the only one who loses will be the survivors of a car crash. Perhaps you would be wise to think about this bill from your personal perspective or your loved ones, if they were involved in a serious car crash, is this truly the insurance regulations that you would want them to be subjected to? I strongly recommend you vote NO on this bill as presented.

Michael F. Dabbs
President, Brain Injury Association of Michigan
Secretary, CPAN

*C: Brain Injury Association of Michigan Attendant Care Position Paper, Working DRAFT
Brain Injury Association of Michigan Fact Sheet
Diagram – What is Acquired Brain Injury
Dingwall Letter, April 16, 2015*

BRAIN INJURY ASSOCIATION OF MICHIGAN

ATTENDANT CARE POSITION PAPER

March 30, 2015

THIS IS A WORKING DOCUMENT INTENDED TO IDENTIFY KEY AREAS OF ATTENDANT CARE AS A GENERAL FRAMEWORK FOR DISCUSSION AND IS NOT INTENDED TO BE ALL INCLUSIVE

PRINCIPLE: It is our belief that for the injured person medical care is paramount and that ensuring the patient receives all care deemed reasonably necessary should be the central focus of discussions on this topic. In nearly all cases, care provided by family members who are appropriately trained to deliver the necessary care, who receive oversight by a trained physician or clinician, is reasonably necessary for the patient's care, recovery or rehabilitation.

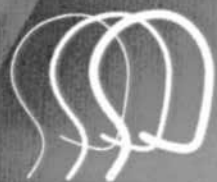
PHYSICIAN DETERMINATION AND OVERSIGHT: Decisions regarding the appropriateness of in-home attendant care, as well as the type, intensity, frequency, level of care, and supervision required, should be made by the treating physician in concert with other clinicians and family members following a comprehensive assessment of the individual's care needs. In-Home Care Plans for attendant care situations for persons with a brain injury are recommended. In-Home Care Plans should have at least annual reviews of the plan; or more frequently if health care needs change. The caregiver's competence to provide the care needed should be monitored as directed in the care plan. Care determination and oversight will be retroactive in those cases with a demonstrated need for review.

CAREGIVER TRAINING: Appropriate training for all caregiver's is required prior to patient's discharge to a home setting. Completion of training can be documented by either a physician or RN – with periodic review of caregiver competency. Caregiver training will be retroactive in all cases- family members may provide proof of competency to physician or RN if previously trained.

HOURLY CARE RECOMMENDATIONS: Generally, no single family member should be responsible for 24/7 care; however, 24/7 care can be rendered by a multiple family members who are appropriately trained. Furthermore, it is recommended that no one person provide care for more than 16 consecutive hours with at least a break of 8 hours. Availability of and use of monitoring devices and other technologies will be considered in determining care needed. Care restrictions are retroactive in most cases unless there is an identified outlier scenario.

AFFIDAVIT OF CARE: Family is to certify that care prescribed has been rendered. Affidavit to be provided for all current and future cases.

REIMBURSEMENT OF CARE: The reimbursement rate should be 90 percent of the commercial rate for the defined geographic region for the level of care that is required. In absence of a rate standard for the injured person's region, then 90 percent of the commercial rate for the state for the level of care provided will be used. Those patients whose caregivers are receiving negotiated levels of reimbursement should not be required to accept lower rates due to changes in the statutory scheme.



**BRAIN INJURY
ASSOCIATION**
OF MICHIGAN

Brain Injury Fact Sheet

Our Mission

To improve the lives of those affected by brain injury and to reduce the incidence and impact of brain injury through education, advocacy, support, treatment services, and research.

Our Vision

Everyone affected by brain injury will have immediate and equal access to services and support to lead a full and meaningful life.

Brain Injury Association of Michigan

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rev. 2/14

Types of Brain Injury

Acquired Brain Injury (ABI)

An injury to the brain which is not hereditary, congenital or degenerative that has occurred after birth. Includes anoxia, aneurysms, infection to the brain, stroke...and traumatic brain injury.

Traumatic Brain Injury (TBI)

A blow or jolt to the head, or a penetrating head injury that disrupts the function of the brain.

In the United States

- 1.7 million Americans sustain a TBI each year.
- More than 52,000 Americans die every year as a result of TBI.
- The risk of TBI is highest among children aged 0-4, older adolescents aged 15-19, and adults older than 75.
- After one brain injury, the risk for a second injury is 3 times greater; after the second injury, the risk for a third injury is 8 times greater.
- TBI is the leading cause of death and disability among youth and young adults nationwide.
- About 75% of TBIs that occur each year are concussions or other forms of mild traumatic brain injury (MTBI).

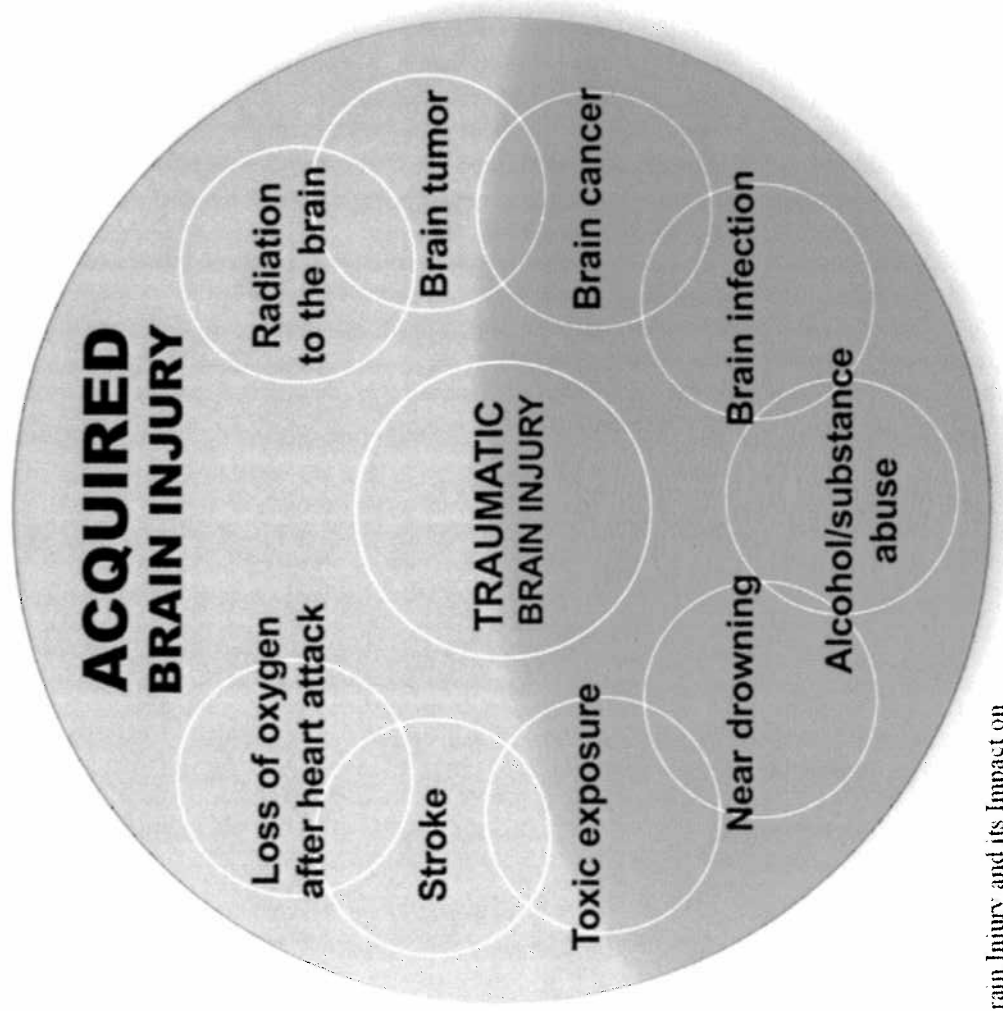
In Michigan, an estimated 58,500 residents sustain a TBI every year. Of these:

FACT

**Approximately
50% of people
hospitalized for
TBI in Michigan
are under age 45.**



WHAT IS ACQUIRED BRAIN INJURY



April 16, 2015

Re: Bill SB 248/249 Substitute Bill

Dear Senators,

Twenty-four years ago my three-year old son and I were involved in a motor vehicle accident. My son sustained a life changing spinal cord injury. This injury left him ventilator dependent and a quadriplegic. He requires 24/7 nursing care.

He has had an open personal injury protection claim (PIP) with a major Michigan insurance company since his injury. The Michigan Catastrophic Fund has provided for all of his medical necessary needs. These expenses have been astronomical. We could not have personally or financially provided the care required for our son. The Michigan Catastrophic Fund provides for his nursing care, medical care from doctors, respiratory therapy, physical therapy, medications and medical equipment. The medical equipment includes a ventilator, hospital bed, lift, assessable bathing and bathroom area, wheelchair, ramps for our home and a wheelchair assessable van.

These items are necessary for him to maintain daily living activities. He is currently working as a dog trainer to help others with special needs to have a service dog. He has completed a public education and is enrolled in online college classes. The excellent care we have been able to provide has enabled him to be a young man who is active in the community and giving back to others. He enjoys going to movies with his friends and bowling. This would not be possible if the Michigan Catastrophic Fund had not been established by the Michigan voters.

Please vote to continue the Michigan No – Fault Law plan. People are not going to make the right decisions on this issue. They must be fully informed about what this would mean to them if they or their family members are involved in a motor vehicle accident. They do not understand what it would take to cover these astronomical expenses. So many individuals will say “I’m not going to have an accident” or “That won’t happen to me.” But it does happen and an auto accident can be life changing. My son did not have a choice: we were hit by a drunk driver. Citizens do not realize the enormous hardships families will endure if limits are put into the new law. Please continue to protect our Michigan Citizens’s by preserving the No-Fault Law as it currently stands.

Sincerely,

Doug, Dora and Scott Dingwall
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